IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et. al.*,

Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS, and DISCO PRESCRIPTION PHARMACY, *et. al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

The National Association of Insurance Commissioners (NAIC) is an unincorporated association whose membership consists of the principal state insurance regulatory officials charged by law with the responsibility of regulating the business of insurance within each state, the

District of Columbia, Guam, Puerto Rico and the Virgin Islands. The NAIC submits this *amicus curiae* brief with the consent of all parties to this case.

The individual state insurance commissioners who comprise the NAIC and the insurance consuming public, on whose behalf they regulate, have a vital interest in the outcome of this case. Since each state regulates the business of insurance as intended by Congress under the McCarran Act, 15 U.S.C. §§1011-15 (1970), any interpretation of that Act which modifies or diminishes the present scope of state insurance regulation would seriously impair the ability of each member of the NAIC to oversee the business of insurance. Affirmation by this Court of the rationale underlying the Fifth Circuit Court of Appeal's decision would, in the opinion of the NAIC, lead to such an impairment. This result would severely and adversely impact on the ability of the states to foster and sanction appropriate efforts and procedures designed to reduce or at least contain the cost of insurance.

The purpose of this brief is to persuade the Court to frame its decision in a manner which preserves the ability of the states to regulate the business of insurance on behalf of the insurance consuming public. The NAIC will specifically argue that an insurer's efforts designed to reduce or contain the cost of insurance through its impact on the settlement and payment of claims constitutes a part of the "business of insurance." In doing so, the NAIC does not necessarily endorse the details of the health care cost control approach embodied in the Blue Shield plan in the instant case.[1] Furthermore, in this brief the NAIC

[1] For example, the question can be raised as to whether the Blue Shield plan would constitute unfair discrimination under the state's unfair trade practice acts on the basis that all insureds pay the same premium but receive different levels of benefits depending upon the pharmacist they choose. A contrary argument is that unfair discrimination does not exist since each insured has the option to purchase from whomever he chooses. Furthermore, it might be argued that the difference in the amount reimbursed essentially reflects the difference in the cost of processing the claims. However, regardless of the merits of the competing arguments, the issue of unfair discrimination is one for decision under the state insurance laws.

does not address the other McCarran Act issues raised in this case, *i.e.*, whether the state of Texas has regulated the challenged activity in this case and whether the challenged activity falls within the boycott exceptions in the McCarran Act sense.[2] Since the Fifth Circuit Court of Appeals definitively addressed only the "business of insurance" issue, the purpose of the NAIC involvement in the instant case is to urge this Court to construe the "business of insurance" language in a manner that will *not* deter or preclude insurer activities aimed at reducing or containing the cost of insurance, *when appropriately regulated by the states,* by rendering such activities vulnerable to an onslaught of antitrust challenges by those feeling a grievance stemming from lower costs and prices.

ISSUE PRESENTED

Are an insurer's efforts and procedures designed to contain or reduce the cost of insurance through the impact on the settlement and payment of claims a part of the "business of insurance" under the McCarran Act?

[2] It should be noted, however, that the district court held that the challenged activities not only constituted a part of the "business of insurance" but also that the State of Texas regulated the Blue Shield activities and that such activities did not fall within the "boycott" exception to the McCarran Act. Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 415 F.Supp. 343, 351 (W.D. Tex. 1976).

ARGUMENT

I. REASON AND LEGAL PRECEDENT REQUIRE A DETERMINATION THAT AN INSURER'S EFFORTS AND PROCEDURES DESIGNED TO REDUCE OR CONTAIN THE COST OF INSURANCE THROUGH ITS IMPACT ON THE SETTLEMENT AND PAYMENT OF CLAIMS IS A PART OF THE "BUSINESS OF INSURANCE" UNDER THE McCARRAN ACT.

Regardless of the merits of the validity of the Blue Shield prepaid prescription drug insurance program under either a particular state's insurance law or the federal antitrust laws, Blue Shield's reimbursement mechanisms, including the Pharmacy Agreement, are designed to minimize the cost of such insurance, especially through its impact on the settlement and payment of claims.

First, costs are minimized by reducing the expenses of processing claims. Second, prediction of costs in meeting the insurer's obligations is rendered more certain, thereby enabling the establishment of a lower premium. Third, the insurer's allowance of cost plus $2.00 dispensing fee to participating pharmacies minimizes the price which must be paid in the settlement of claims, thereby enabling a lower price for the insurance coverage. Furthermore, to the extent participating pharmacies are a significant competitive force in the market for prescription drugs, the impact of competitive pricing in the overall market is enhanced. This, in turn, further impacts on the aggregate level of claims to be paid by the insurer and the cost of insurance to its insureds. Finally, the nonparticipating pharmacists, in addition to being subject to competitive price pressures stemming from the prices solicited by the insurers, are

also subject to competitive price pressure due to the fact that the insureds purchasing drugs are limited to a 75% reimbursement.

The competitive pressures for reduced prices and/or improved services are not only recognized by the Respondents in this case but also serve as the basic reason for the initiation of this litigation. *Royal Drug Company, Inc. v. Group Life & Health Insurance Co.,* 556 F.2d 1375, 1378-79 (5th Cir. 1977). Thus, regardless of the other merits or demerits of the Blue Shield prescription drug program, it is clear that Blue Shield is trying to reduce or contain the cost of prescription drugs thereby generating lower cost prescription drug insurance than would otherwise be available.

The lower court concluded, however, that "Blue Shield's Pharmacy Agreement is not a part of the business of insurance" under the McCarran Act and consequently not immune from the application of the federal antitrust laws. *Id.* at 1387. This conclusion is based upon the court's interpretation of *SEC v. National Securities, Inc.,* 393 U.S. 453 (1969). The NAIC submits that the lower court's interpretation is erroneous both in terms of reason and as a matter of law.

A. Reason and Existing Legal Precedent Require a Finding That the Challenged Activity is the Business of Insurance Under the McCarran Act.

In *National Securities* this Court said:

> The statute [McCarran Act] did not purport to make the States supreme in regulating all the activities of insurance companies; its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the business of insur-

ance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. *Certainly the fixing of rates is part of this business;* that is what South-Eastern Underwriters was all about. The selling and advertising of policies . . . and the licensing of companies and their agents, . . . are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance . . . . *The relationship between insurer and insured,* the type of policy which could be issued, its reliability, interpretation, and enforcement — *these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. *But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."* 393 U.S. 453, 459-60 (emphasis added).

Thus, the basic issue of whether the challenged activity is the "business of insurance" depends upon whether such activity involves *"the relationship between the insurance company and the policyholder." See also Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093 (1973).

The premium which an insured pays for insurance coverage is a fundamental element in the insurer-insured relationship. This Court confirmed such an obvious conclusion when it made clear that state regulation constitutes the regulation of the "business of insurance" when it exercises control over the price of insurance. *National Securities,* 393 U.S. at 460. Since the underlying costs of

a product or a service bear a substantial relationship to the price charged to customers, *Proctor v. State Farm Mutual Automobile Insurance Co.,* 561 F.2d 262, 268-69 n.11 (D.C. Cir. 1977), it seems axiomatic that, subject to some limiting parameters, an insurer's activities designed to reduce or contain the underlying cost of insurance, and thereby enable a lower insurance price, also involve the insurer-insured relationship.[3] In turn, under the standards of the *National Securities* case, such activity constitutes a part of the "business of insurance."

The decision of the lower court in the instant case is in direct conflict with the decisions of other district and circuit courts which support the proposition that an insurer's efforts to reduce or contain the cost of insurance is a part of the "business of insurance." For example, in the leading decision of *Travelers Insurance Co. v. Blue Cross* the plaintiff commercial insurer brought an antitrust action against Blue Cross whose standard contract with hospitals prescribed the amounts and terms pursuant to which Blue Cross would pay for services rendered by the hospital to the Blue Cross subscribers (insureds). This standard contract with the hospital contained limitations as to the types of costs which Blue Cross would have to reimburse as well as a ceiling on costs. As a result, Blue Cross was able to quote correspondingly lower premiums. 481 F.2d at 82. If the hospital refused to enter into such a contract, Blue Cross would reimburse the hospital on a

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[3] Several state court decisions have recognized the close relationship between the premium rates charged to policyholders and the contractual rates at which health insurers reimburse health care providers. In *Thaler v. Stern,* 253 N.Y.S.2d 622, 631 (1964), a New York Supreme Court described the relation between health insurance rates and hospital repayment rates as being "elemental." *See also In re* Rate Filing of Blue Cross Hospital Service, Inc., 214 S.E.2d 339, 344-45 (W. Va. 1975).

per diem basis in an amount insufficient to cover the hospital's cost. The hospital would then have to charge the patient directly for the balance. Blue Cross raised the McCarran Act defense to the plaintiff's antitrust allegations. The Third Circuit Court of Appeals, in applying the standards of the *National Securities* case, concluded that the rates Blue Cross charged to its insureds were so interrelated with the terms in the hospital contracts that the latter constitute part of he "business of insurance" within the meaning of the McCarran Act. *Id.* at 83.

The Fifth Circuit Court of Appeals, in the instant case, attempted to distinguish *Travelers* on the basis that the insurance commissioner in Pennsylvania was exerting pressure on the insurers to reduce health care costs. 556 F.2d at 1382. However, the Third Circuit Court of Appeals in *Travelers* made clear that the hospital reimbursement plan was at the heart of the "business of insurance" in holding that

> In the present case, the district court found that the interrelationship of hospital payments and subscribers' rates was such that Blue Cross' arrangement with hospitals should be considered part of the "business of insurance." This conclusion is a sound construction of the law and is amply supported by the evidence. 481 F.2d at 83.

Thus, it is clear that the existence of state statutory authority and regulatory activity concerning the insurer reimbursement contracts with hospitals, upon which the Fifth Circuit Court of Appeals bases its distinction, relates to the issue whether the state has regulated the "business of insurance," not whether the activity involved constitutes a part of the "business of insurance."[4]

[4] In its opinion in the instant case, the Fifth Circuit Court of Appeals suggests that the instant case is more akin to *Battle v. Liberty National Life Insurance Co.*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975) than to *Travelers*. 556 F.2d at 1383. Such a conclusion is erroneous for at least two reasons. First, *Battle* is clearly distinguishable on the facts. In that case, the defendant insurer issued burial insurance. The insurer contracted with its wholly owned subsidiary to provide the merchandise and service required by the insurance policy. The subsidiary, in turn, contracted with independent funeral homes to perform the obligations under the insurance policy. If the insured went to a participating funeral home, the level of benefits he would have received were significantly greater than if he went to a nonparticipating funeral home.

Several funeral home directors brought an antitrust action against the insurer and its subsidiary. The court in *Battle* clearly distinguished between the facts in *Travelers* and those in *Battle*. As to the former, the court in *Battle* said

> [s]ignificantly, the relationship between the insurance company and the hospitals in *Blue Cross* was a direct contractual relationship. The result of this contract was simply the performance of the insurer's responsibilities owed to the insured under the insurance contract and nothing more.
>
> . . . .
>
> The contractual relationship in the instant [*Battle*] case is not a direct relationship between the insurance company . . . and the funeral directors. . . .
>
> The addition of this [subsidiary company] intermediary is significant because, under the guise and with the assistance of [the . . . subsidiary, the insurer] may have exceeded the business of providing burial insurance and encroached upon the business of providing funeral services. 493 F.2d at 50.

In the instant *Royal Drug* case, Blue Shield contracted directly with the pharmacists. No subsidiary intermediary was involved. Thus, the language in the *Battle* opinion itself leads to the conclusion that *Travelers*, not *Battle*, is more akin to the instant case. *See also* Proctor v. State Farm Mutual Automobile Insuance Co., 561 F.2d 262, 270 (D.C. Cir. 1977).

The *Royal Drug* case is distinguishable from *Battle* on a second basis as well. The Blue Shield contract with the participating pharmacists is clearly designed as a means to reduce the cost of health care and thereby the rates for the prescription drug insurance. The facts in *Battle* apparently did not suggest the same conclusion to the court thereby failing to invoke the insurer-insured relationship criterion under *National Securities*.

The same conclusion reached in *Travelers* was also reached in *Frankford Hospital v. Blue Cross,* 417 F. Supp. 1104, 1109 (E.D. Pa. 1976), *aff'd per curiam,* 554 F.2d 1253 (3rd Cir. 1977) and *Doctors, Inc. v. Blue Cross,* 360 F.Supp. 693 (E.D. Pa. 1973), *aff'd per curiam,* 535 F.2d 1245 (3rd Cir. 1976). *See also Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 1199 (E.D. Mich. 1973) in which the court held that "[t]he basic function of Blue Cross of providing pre-paid hospital care is clearly the 'business of insurance' ", *id.* at 1211, and that "the negotiation of contracts with non profit hospitals as regulated by Act 109 constitutes 'acts in the conduct' of such business", *id,* as is the "[e]nforcement of the qualification standards adopted by Blue Cross. . . ." *Id.* The qualification standards deemed to be a part of the "business of insurance" in the *Nankin* case arose from the "concern over rising costs of hospital care. . . ." *Id.* at 1230.

In *Manasen v. California Dental Services,* 424 F.Supp. 657 (N.D. Cal. 1976), the court held that the McCarran Act applied to a nonprofit operation which administered prepaid dental care programs through agreements with various subscriber groups and subscriber purchasers. The subscribers paid periodic premiums to California Dental Service in exchange for future dental services to individuals on whose behalf the premiums were paid. The professional services were performed by either "participating" dentists who agreed to seek payment solely from California Dental Services based upon an approved fee schedule or by "nonparticipating" dentists who did not agree to so limit their charges. Patients obtaining care from participating dentists were entitled to full benefits under the program whereas the other patients received less than full coverage. The plaintiffs alleged that this

program violated the antitrust laws by conspiring to fix dental fees and boycotting those dentists who refused to participate. The court focused on the issue whether a cost containment program, which is conceptually identical to the Blue Shield arrangement in the instant case, constitutes the "business of insurance." The court concluded:

> It is undisputed that *the level of dentists' fees are a major factor in determining policy premiums.* CDS' payment arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, *the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act. Id.* at 666-67 (emphasis added).

Similarly, *Anderson v. Medical Service,* CCH TRADE REG. REP. (1976-1 Trade Cases) ¶ 60,884, at 68,885 (E. D. Va. 1976), *aff'd,* 551 F.2d 304 (4th Cir. 1977), involved an antitrust action by a physician against a prepaid medical-surgical insurance plan which distinguished between participating and nonparticipating physicians as to reimbursement methods. In upholding the reimbursement methods as part of the "business of insurance" under the McCarran Act, the court said that "[t]he business of insurance refers not only to the relationship between an insurer . . . and its policyholders, it refers also to those other activities which relate so closely thereto that they must be placed in the same class." *Id.* at 68,857. The closely-related activities referred to in this case were the insurers' contracts with health care providers designed in a manner to contain health care costs.

Applicable precedents in other insurance areas support the inclusion of arrangements between insurers and per-

sons other than policyholders which are aimed at reducing or containing the cost of insurance within the term "business of insurance". For example, in *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977), four automobile repair shops alleged that the claim adjustment and settlement practices of five automobile insurance companies involved price fixing, coercion and a group boycott. The district court granted summary judgment in favor of the insurers on the basis of the McCarran Act. On appeal, the repair shops asserted that the disputed practices were not a part of the "business of insurance" and the boycott exception to the McCarran Act was applicable.

The repair shops conceded that the challenged activities stemmed solely from the insurers' "desire to slow the rate of increase in the claims payments required to satisfy the companies' contractual obligations to their policyholders," *id.* at 268, and that the "purpose was to minimize increases in the cost of reimbursing damage claims." *Id.* at 271. To achieve these objectives, the repair shops alleged that the insurers agreed, as a basis for settling claims, to reimburse their policyholders according to a common formula involving the prevailing labor rate, a standardized estimate of the amount of labor required and a compulsory discount on parts. Such an alleged agreement was enforced, the repair shops argued, through preferred repair shops who under economic pressure committed themselves to repairing on the insurers' conditions. Policyholders could obtain their repairs from other shops but there was no assurance that they would be reimbursed in full by the insurer if such shops charged a higher price. Thus, the facts are comparable to participating-nonparticipating arrangements in the health care provider cases discussed above.

Commencing its analysis with the standards set down by this Court in the *National Securities* case, the Circuit Court of the District of Columbia concluded that

> the alleged horizontal agreement to pay insureds' claims on the basis of the prevailing labor rate, as well as appellees' supposed adherence to a common formula to compute damage estimates, *fits within the "core" of the "business of insurance."* The essence of the automobile insurance contract is the insurance company's agreement, in return for a premium, to make payments to or on behalf of the policyholder for losses arising out of the ownership, maintenance, or use of an automobile. *The determination by the insurance company of the amount to be paid in discharge of this contractual obligation is at the heart of the relationship between insurer and insured,* and is directly connected with the reliability, interpretation, and enforcement of the insurance contract. 561 F.2d at 267 (emphasis added).

As to the alleged arrangement with the preferred body repair shops the court rejected the argument that the arrangement was the business of automobile repair rather than the business of insurance:

> In the circumstances of this case, we conclude that the alleged agreements with preferred shops and the asserted group boycott of non-cooperative shops *are connected closely enough to the contractual relationships* between the appellees and their policyholders, and with the reliability, interpretation, and enforcement of those contracts, to qualify as the business of insurance [emphasis added].
>
> . . . .
>
> *Notwithstanding their effect on non-policyholders, the activities unquestionably grow out of and are tied to, the* claims adjustment and settlement process [emphasis added].
>
> . . . .

Of central significance in this entire context is the close relationship between the cost of reimbursing damage claims, on the one hand, and the insurance rates charged by appellees, on the other. Any doubt as to whether these activities should be deemed to fall within the business of insurance is ponderably eased by that economic reality. *Indeed, in a case involving similar activities, the Third Circuit concluded that a substantial impact on rates, in and of itself, was sufficient to satisfy the statutory standard,* [emphasis added] based on the language in *National Securities* to the effect that the business of insurance includes "other activities of insurance companies [which] relate so closely to their status as reliable insurers."

. . . .

For the purposes of this case, it is sufficient to say that the vital impact on appellees' rates, found by the District Court, provides additional support for our conclusion that the disputed practices are a part of the of the business of insurance. Id. at 268-70 (citations omitted) (emphasis added).

Although the circuit court noted that it did not have to "decide whether a substantial effect on rates, standing alone, is enough to qualify an activity as the business of insurance," *id.* at 269, the language in the opinion comes close to doing so. Certainly, the court gives such impact on rates substantial weight. Furthermore, the court made clear that when an insurer's activity relates to both its "claims adjustment and settlement process" and to the "cost of reimbursing claims" which, in turn, is closely related to the "insurance rates charged," such activity clearly constitutes a part of the "business of insurance."

Although the insurer-health care provider cases cited and discussed *supra* may suggest that whenever an insurer undertakes efforts to reduce the cost of insurance, such

activity constitutes a part of the "business of insurance," the NAIC does not maintain that there are no activities beyond the parameters of the McCarran Act exemption. Insurance company activities that may impact on the cost of insurance which are undertaken from other than the perspective of the policyholder-insurer relationship may exceed the outer boundaries of the "business of insurance." Or, the interjection of insurer involvement into the relationship between two or more noninsurer entities in an effort to raise a McCarran Act shield for noninsurance activities from antitrust sanctions may also be beyond the outer limits. *See Battle v. Liberty National Life Insurance Co.,* 493 F.2d 39 (5th Cir. 1974), *cert. denied,* 419 U.S. 1110 (1975). Or, activities which have only a *de minimis* impact on the cost of insurance may also be outside the "business of insurance" sphere. *See Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80 (3rd Cir.), *cert. denied,* 414 U.S. 1093 (1973). But, whatever the outer limits, it is clear that an insurer program aimed at the reduction or containment of the cost of insurance through its impact on the settlement and payment of claims is a part of the "business of insurance." Such a program very comfortably fits within the potentially more limited bounds of *Proctor* and even more easily within the parameters of the health cases discussed above.

The Blue Shield prepaid drug insurance program clearly is embraced by even the potentially more limited standard of *Proctor.* The program aims at the containment of costs. It does so by impacting on the claims settlement and payment process which is a substantial area for potential reduction in insurance costs. *See Proctor v. State Farm Mutual Automobile Insurance Co.,* 561 F.2d at 268-69 n.11. The Pharmacy Agreement provided

a means for the insurers to establish a claim settlement process and claim payment levels as well as introduce economic pressures for lower cost of drugs. Lower claim costs, in turn, enable lower insurance rates. As *Proctor* makes abundantly clear, the price of insurance, the handling of claims and the interrelationship of the two are part of the essence of the "business of insurance." Clearly, the Blue Shield program in this case was undertaken from the perspective of the insurer-insured relationship and consequently is a part of the "business of insurance."

B. The Decision of the Fifth Circuit Court of Appeals in the Instant Case is Premised on Several Reasons Which Are Factually Unsound and Legally Irrelevant.

Even though the fifth circuit has chosen to depart from the majority of courts which have found cost containment procedures by insurers to be part of the "business of insurance" under the McCarran Act, such departure would be understandable if the court had based its holding on sound legal reasoning. Unfortunately, this is not the case. The lower court's rationale for rejecting cost containment efforts as part of the "business of insurance" suffers from several unsound and irrelevant premises.

1. Pharmacy Relationships Are Not "Primary".

The lower court appears to accept the notion of the Respondents that the challenged activity "relate[s] primarily to relationships other than that between the insurer and its policyholder," 556 F.2d at 1380, and that "the relationship primarily affected by the Pharmacy Agreement . . . is that between competing pharmacies and not the relationship between insurer and insured." *Id.* at 1381. This

rationale lacks merit as a basis for decision for at least two reasons. First, insurer efforts to use the claims settlement process to control the cost of health care services and the premium rates directly affect every insured. The number of actual or potential insureds is literally conterminous with the extent of the entire population. Thus, the bald statement that the primary relationship involved is that between competing pharmacies lacks support in fact and reason. Quite the contrary, the primary relationship involved in this case is the one between the insurer and insured. Second, even assuming *arguendo* that there may be some question as to what is the primary relationship, the criteria enunciated by this Court in *National Securities* does not include primacy as a factor. *See* 393 U.S. at 453. This Court said that if the activity in question involves the "relationship between insurer and insured," it constitutes a part of the business of insurance. *Id.* at 460. There was no suggestion that the insurer-insured relationship had to be "primary." In short, the primacy argument is legally irrelevant as well as factually unsound.

2. Impact on Noninsurance Business is Not a Determining Factor.

There is some suggestion in the Fifth Circuit Court of Appeals' opinion that the more the conduct of the insurance business impacts on the noninsurance business, the less it becomes the "business of insurance." *See* 556 F.2d at 1383. This notion is also incorrect. The challenged activities in *Travelers, Frankford Hospital* and *Nankin Hospital* unquestionably affected the business of hospitals; the challenged activities in *Manasen* and *Anderson* undoubtedly impacted upon the business of dentistry and physicians; and the challenged activities in *Proctor* certainly impacted on the business of automobile repair. In

each case, however, the fact that the challenged activity impacted on some noninsurance business did not render such activity any less the "business of insurance."[5] Since a major function of an insurer is to be, in effect, a substitute purchaser of goods and services called for in the insurance contract, the "business of insurance" must necessarily impact on the suppliers of such goods and services. The District of Columbia Circuit Court of Appeals explicitly dealt with this question when it held that "the fact that a practice may affect other types of business is not dispositive of whether it is sufficiently related to the business of insurance to come within the McCarran Act's protection." *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d at 268.

3. The Rationale that Blue Shield is Not Obligated to Fix Drug Prices is Irrelevant.

A third rationale posed by the lower court as a basis for its decision is the conclusion that "Blue Shield is [not] obligated to fix the retail prices of pharmaceuticals." 556 F.2d at 1381. This rationale also fails on both factual and legal relevancy bases. First, categorizing the Blue Shield as a price fixing scheme is subject to question. As an insurer, Blue Shield is a substitute purchaser of prescription drugs. In mailing a copy of the Pharmacy Agreement to each licensed pharmacist, Blue Shield in effect extended an offer to purchase drugs at cost plus a $2.00 dispensing fee minus a maximum $2.00 deductible to be collected from the insured. Pharmacists, on an individual basis, decided whether to accept or reject this offer. The price payable is not uniform since the underlying cost can vary

[5] In this context, it should be noted that "[t]he plaintiffs [Respondents] concede that there may be effects on policyholders resulting from the Pharmacy Agreement," 556 F.2d at 1380, and "the contractual agreements here under review are somewhat related to the business of insurance." *Id.* at 1383-84.

from pharmacist to pharmacist. Furthermore, if the price offered by Blue Shield did not fall within reasonable market parameters, presumably most pharmacists would have rejected the offer. The mail offer technique used by Blue Shield, in effect, was one method by which a reasonable market price could be determined.

> In its negotiating with [suppliers of services, the insurer] has done no more than conduct its business as every rational enterprise does, i.e. get the best deal. *Travelers Insurance Co. v. Blue Cross,* 481 F.2d 80, 84 (3rd Cir.), *cert. denied,* 414 U.S. 1083 (1973).

Consequently, categorizing this activity as price fixing is a very questionable statement, particularly since there is no uniform rate.

Second, the Pharmacy Agreement is inextricably intertwined with Blue Shield's obligation under the insurance policy.[6] Prepaid health insurance issued by Blue Cross and Blue Shield obligates the insurer (Blue Shield in this case) to provide specified health care services to its insureds. "The basic function of Blue Cross [or Blue Shield] of providing prepaid hospital [or other types of health] care is clearly 'the business of insurance.'" *Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 1199, 1211 (E.D. Mich. 1973). To meet these obligations, the insurer must contract with providers of health care services such as physicians, hospitals, dentists and pharmacists. The satisfaction of the claims for service is the responsibility of the insurer and as such is core of the

[6] This point is more fully developed in Petitioners' Brief. *See also* Petition For a Writ of Certiorari by Group Life & Health Insurance Co. at 10; Brief of Appellee Group Life & Health Insurance Co. at 17-20, Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 556 F.2d 1375 (5th Cir. 1977).

business of insurance. *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d at 268. Determination of what to pay to whom in order for the service benefit of the policy to be provided is a fundamental aspect of the "business of insurance."

Finally, and most conclusively, even assuming *arguendo* that Blue Shield has no obligation under its insurance policy to enter into the Pharmacy Agreement, this Court in *National Securities* clearly indicated that activities other than the performance of contractual legal obligations between the insurer and insured may constitute a part of the "business of insurance."[7] For these various reasons, both individually and collectively, the "obligation" rationale of the lower court does not withstand scrutiny.

4. Application of "Peculiar to Insurance Business" Concept Does Not Support the Lower Court's Decision.

The Fifth Circuit Court of Appeals also appears to have based its decision on the grounds that the challenged activities — the cost control incentives associated with the Pharmacy Agreement — are not peculiar to the insurance industry and, consequently, do not constitute a part of the "business of insurance." 556 F.2d at 1383, 1386. However, the mere fact that an insurer engages in an activity whose nature is akin to the activities of noninsurers does not render the insurer's activity outside the "business of insurance." For example, setting a price for one's product or service is not peculiar to the insurance business. All enterprises must do so. Nevertheless, this Court has made abundantly clear that the "fixing of rates is a part of this

[7] For example, in *National Securities* this Court indicated that merger activities substantially involving the security of and service to be rendered to an insured is a part of the "business of insurance." 393 U.S. at 462.

business [of insurance]", *SEC v. National Securities, Inc.*, 393 U.S. at 459, even though it is not peculiar to insurance. Similarly, even though an insurer's efforts to contain its underlying costs are not peculiar to the insurance business, such fact does not divorce such efforts from the business of insurance. Furthermore, two of the cases cited by the lower court to support the "peculiar to the insurance industry" theory lead to the opposite conclusion.[8]

[8] The first case, *Center Insurance Agency, Inc. v. Byers*, CCH TRADE REG. REP. (1976-1 Trade Cases) ¶ 60,940, at 69,122 (N.D. Ill. 1976), involved one insurance agency attempt to pirate trade secrets concerning policy and advertising practices from another insurance agency. The district court concluded that this activity was not the business of insurance on the basis that "[t]he relationship between the insurance company and its policyholders was not involved and there was no effect on insurance rates." *Id.* at 69,125. Although the court referred to the "peculiar" concept, it was not faced with a factual setting which involved the "relationship between the insurer and the insured". Since the instant case involves an effect on rates and the insurer-insured relationship, the *Center Insurance Agency* case undermines rather than supports the Respondents' position.

The second case, *American Family Life Assurance Co. v. Planned Marketing Associates, Inc.*, 389 F.Supp. 1141 (E.D. Va. 1974), similarly involved efforts to induce one insurer's agents to switch to another company, to divulge trade secrets, etc. Here, too, the court interpreted *National Securities* to mean that the " 'business of insurance' pertained to activities *peculiar* to the insurance industry." *Id.* at 1145. But, similar to *Center Insurance Agency*, the court stated that "[a]cts peculiar to the insurance industry would include such things as the relationship between the insurer and the insured. . . ." *Id.* The lower court in the instant case failed to discern that these two decisions make clear that the "peculiarity" concept is not separate and independent of the basic standard that those activities involving the insurer-insured relationship are a part of the "business of insurance."

In addition, the lower court erroneously cites *American General Insurance Co. v. FTC*, 359 F.Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974) in support of the proposition that activities of insurers not peculiar to insurance companies are outside the scope of the McCarran Act. That case involved the application of the Clayton Act to a merger between two insurance companies. The insurer brought an action for declaratory and injunctive relief to de-

5. The Lower Court Succumbed to the Antitrust Rhetoric of Respondents.

Lacking a firm legal foundation upon which to base their argument concerning the "business of insurance" issue, the Respondents employed antitrust labels and rhetoric to "color" their case despite its lack of legal relevance. For example, the Respondents argued that

> DEFENDANT'S ACTIVITIES IN CONSPIRING AND AGREEING TO FIX RETAIL SALES PRICES, IN CONSPIRING TO EFFECT A BOYCOTT OF PLAINTIFFS, AND IN CONSPIRING TO FORECLOSE PLAINTIFFS FROM A SUBSTANTIAL PORTION OF THE MARKET DO NOT CONSTITUTE THE BUSINESS OF INSURANCE.[9]

Similar language is liberally sprinkled throughout the briefs of the Respondents.[10] In choosing this language, the

clare that the FTC lacked jurisdiction. The case was decided on the basis that the insurers had not yet exhausted their administrative remedies. 496 F.2d at 197. It was only in *dicta* that the district court addressed the McCarran Act issues. Furthermore, the court's discussion as to the business of insurance issue made no reference to an independent concept of "peculiarity," thereby providing no support to the Respondents' position in the instant case. And finally, it should be noted that the Fifth Circuit Court of Appeals affirmation in the *American General* case did not go to the district court's *dicta* but rather deferred the McCarran Act issues until there was a review of a final agency order. 496 F.2d at 197. Subsequent to the fifth circuit ruling the FTC has taken final administrative action, which is now being reviewed by the Ninth Circuit Court of Appeals. American General Insurance Co. v. FTC (No. 77-3207, filed December, 1977). It should be noted that the NAIC has filed an *amicus curiae* brief therein.

[9] Plaintiff's Brief in Opposition to Defendant's Motion to Dismiss at 13, Royal Drug Company, Inc. v. Group Life & Health Insurance Co., 415 F.Supp. 343 (W.D. Tex. 1976).

[10] For example, the Respondents assert conclusions of law as being facts in their Brief in Opposition to Petition for Writ of Certiorari at 6-12.

Respondents are using legal conclusions which cannot be arrived at until this case is tried on the merits under the antitrust laws. In fact, it would appear that such conclusions cannot be supported.[11] Furthermore, and even more important, Respondents' assertion that antitrust violations do not constitute the "business of insurance" is irrelevant since the application of the McCarran Act is not dependent upon a determination that there is no antitrust violation. *See Dexter v. Equitable Life Assurance Society,* 527 F.2d 233, 236 (2d Cir. 1975).

[11] Price fixing under section 1 of the Sherman Act may take one of two forms. One form involves vertical resale price maintenance which is irrelevant to the instant case. The second form refers to an arrangement between competitors. The essence of such price fixing is agreement with competitors. United States v. Citizens & Southern National Bank, 422 U.S. 86, 116 (1975); United States v. Columbia Pictures Corp., 169 F.Supp. 888, 893 (S.D.N.Y. 1959); Kiefer-Stewart Co. v. Seagrams & Son, 340 U.S. 211, 213 (1951).

The instant case contains no suggestion (1) that Blue Shield entered into any agreement with competing insurers, (2) that the success of Blue Shield's cost containment efforts depended upon Blue Shield inducing an agreement between competing pharmacists or (3) that, in the absence of the Blue Shield offer, competing pharmacists had any economic inducement to agree among themselves to charge a *lower* price. The fact that some of the participating pharmacists are also Respondents in this case challenging the Blue Shield Pharmacy Agreement strongly suggests that the inducement to enter into the Agreement was rooted in concern over competitors selling at lower prices not in a conspiracy among competing pharmacists. In short, the assertion of price fixing in the instant case, which requires a combination or conspiracy in restraint of trade, is not founded on economic sense.

Nor is mere parallel behavior among competitors sufficient by itself to show a conspiracy under section 1 of the Sherman Act. Theater Enterprises, Inc. v. Paramount Film Distributing Corp., 346 U.S. 537, 541 (1954). The crucial question in conspiracy cases is whether parallel business behavior could have been the product of independent decision. *Id.* at 540-41. *See also* Pevely Dairy Co. v. United States, 178 F.2d 363 (8th Cir. 1949), *cert. denied,* 339 U.S. 942 (1950). The facts in the instant case, including the absence of allegations that the participating pharmacists negotiated with one another, suggest that pharmacists' acceptance of the Blue Shield offer were the product of

Instead, appropriate analysis must avoid the facile use of conclusional rhetoric and look at the actual activities and facts which underlay the purported antitrust violations to determine whether such activities constitute the "business of insurance" under the McCarran Act. The Third Circuit Court of Appeals has noted the tendency in antitrust cases to employ antitrust "jargon" or labels as "a kind of semantic shell game, resting more on key words than on careful analysis." *Ungar v. Dunkin' Donuts of America, Inc.*, 531 F.2d 1211, 1222 (3rd Cir.), *cert. denied*, 429 U.S. 823 (1976). The Court itself has cautioned that the issues raised in antitrust litigation are not to be governed by labels or "key words" selected by counsel: "Invocation of mechanical word formulas cannot be made to substitute for adequate probative analysis," *FTC v. Sun Oil Co.*, 371 U.S. 505, 527 (1963). Unfortunately, in the instant case the lower court fell prey to the Respondents' use of antitrust conclusional labels in finding that the challenged activities were not the "business of insurance", 556 F.2d at 1381, 1383-4, 1386. As a consequence, the "coloring" of the court's perspective through its erroneous approach not only undercuts the persuasiveness of the decision, but also tends to explain the contorted rationale in the opinion.

In summary, the price which an insured pays for insurance is a fundamental element in the insurer-insured relationship, as are efforts to reduce or contain the underlying costs. As a consequence, such efforts are a part of

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independent judgment. Further indication that the Blue Shield program does not violate the federal antitrust laws is the Department of Justice determination, pursuant to its business review procedure, not to initiate any proceeding against a similar Blue Shield program. *See* Motion for Leave to File and Amicus Curiae Brief of Blue Shield Association in Support of the Petition for a Writ of Certiorari at 17a (Dep't of Justice Clearance of Jan. 15, 1968).

the "business of insurance," particularly when achieved through an impact on the settlement and payment of claims process. In applying the standards of *National Securities* several district and circuit courts have reached this very conclusion. The lower court's various rationales in the instant case, upon which the opposite result is premised, defy reason and lack legal relevance.

II. PUBLIC POLICY REQUIRES THAT INSURER EFFORTS AND PROCEDURES DESIGNED TO REDUCE OR CONTAIN THE COST OF INSURANCE BE CONSIDERED A PART OF THE "BUSINESS OF INSURANCE" UNDER THE McCARRAN ACT.

The aggregate cost of health care in the United States has soared tremendously in recent years.[12] The average annual percentage changes in medical care prices have substantially exceeded the inflation rate for other goods and services.[13] As a consequence, the escalation of costs in the delivery of health care has become a high priority government concern. Demands for national health insurance are tempered by the need to contain health care

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[12] Costs have soared from $12 billion in 1950 to $139 billion in 1976. U. S. DEP'T COMMERCE, BUREAU OF THE CENSUS, 1977 STATISTICAL ABSTRACT 94 (1977).

[13] There was a 9.3% increase in medical care costs in 1974, 12% in 1975 and 9.5% in 1976. *Id.* Between 1967 and 1976, the price of a semi-private hospital room has increased 169%, while physician fees increased 89%, dentists 72% and drugs 59%. *See id.* The average cost to a hospital for a patient's one-day stay reached $151 in 1975, and the average patient stay cost $1,164 in 1975. *Id.* at 98. If present inflation rates for hospital care continue, an average hospital stay will cost $2,600 by 1982. *Joint Hearings on H.R. 6575 Before the Subcomm. on Health of the House Comm. on Ways and Means and the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 95th Cong., 1st Sess. 13 (1977).

costs which have priced some segments of our society out of the market. The central public policy issue posed in this case is whether insurers, subject to appropriate state regulation, are to be part of the problem or part of the solution of controlling health care expenses.

A. The Public Policy of Health Care Cost Containment.

The escalating cost of delivering health care services to the American public has generated a growing consciousness among all segments of society that cost containment must be achieved before significant advances can be made in the quality and availability of existing health care programs. This consciousness is being translated into tangible public policy at all levels of government. Such policy is bringing substantial pressure to bear on insurers and state governments to undertake measures to contain or reduce the cost of health care.

1. Expressions of Public Policy.

The translation of public awareness of the importance of health care cost containment into public policy can be traced to a number of sources at both the federal and state levels.

a. Enunciated Federal Policy. Federal policy on health care cost escalation has been enunciated unequivocally by both the Congress and the Administrations of Presidents Ford and Carter. The Department of Health, Education and Welfare has given "highest priority to efforts directed toward the containment of health care costs."[14] The Federal Trade Commission has shown a re-

[14] U.S. DEP'T HEALTH, EDUC. & WELFARE, PUBLIC HEALTH SERVICE, FORWARD PLAN FOR HEALTH FY 1978-82, at 3 (1976).

cent interest in reducing the "inflationary aspects" of the Blue Shield reimbursement payment mechanism through limitations on fee increases and review of covered services.[15] These efforts, along with the President's hospital cost containment proposal,[16] reflect the federal government's commitment and pressure to contain health care costs.

Federal involvement in controlling the escalation of health costs has flowed especially from the creation and experience of federal health insurance programs. For example, combined Medicare and Medicaid expenditures by the federal government have risen from $9.9 billion in 1970 to an estimated $32.2 billion in 1977.[17] Within a few short years after the enactment of Medicare legislation, future cost projections were being revised markedly upwards because of soaring costs attributed to provider cost increases and greater than anticipated utilization rates.[18]

Experience with the federal insurance programs has led to numerous proposals and actions to contain costs. Congress in 1972 enacted substantial measures designed to control costs in Medicare and Medicaid through hos-

[15] *See Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Relations*, 95th Cong., 2d Sess. — (Mar. 21, 1978) (testimony of FTC Chairman Michael Pertschuk).

[16] *See Joint Hearings on H.R. 6575, supra* note 13.

[17] 1977 STATISTICAL ABSTRACT, *supra* note 12, at 249.

[18] STAFF OF THE SUBCOMM. ON HEALTH & THE ENVIRON. OF THE HOUSE COMM. ON INTERSTATE & FOREIGN COMMERCE, DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES FISCAL YEARS 1966-76, 94th Cong., 1st Sess. 3 (1976).

pital cost and physician fee limitation authorities.[19] The House report accompanying the 1972 bill stated that

> Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.[20]

In 1976, the Secretary of HEW noted the intensity of the federal government's response to cost escalation in saying that HEW "is vigorously attempting to control costs in the Federal programs through its hospital cost and physician fee limitation authorities obtained through the 1972 Social Security Amendments."[21] Furthermore, in the administration of Medicare by private insurance carriers, insurers are specifically authorized to make determinations as to the reasonableness of charges or costs.[22]

Other federal initiatives relevant to cost containment include professional standards review[23] and health maintenance organization legislation.[24] Professional Standards Review Organizations (PSRO) are charged with the responsibility of determining medical necessity in the rendering of health care in connection with federal in-

[19] *See, e.g.*, 42 U.S.C.A. §§ 1395b-1; 1395f(b); 1395u(b)(3); 1395y(d); 1396B(i) (1974).

[20] H. Rep. No. 92-231, 92d Cong., 2d Sess. (1972), *reprinted in* 3 U.S. CODE CONG. & AD. NEWS 4989, 5069 (1972).

[21] *Hearings on S. 3205 Before the Subcomm. on Health of the Senate Comm. on Finance*, 94th Cong., 2d Sess. 30 (1976).

[22] 42 U.S.C.A. §§ 1395u(a)(1), 1395u(a)(3) (1974).

[23] *See id.* §§ 1301, 1320c.

[24] *See id.* § 300e (Supp. 1977).

surance programs administered under social security. In acting upon PSRO legislation, it was the purpose of Congress to assure that payment for medical services would be made only when and to the extent of medical necessity. Federal health maintenance organization (HMO) legislation was intended to stimulate alternative delivery mechanisms for health care services. HMO's operate on a predetermined, prepaid premium basis which, in contrast to traditional fee-for-service payments, creates incentives to the provider of health care to operate efficiently.

Medicare and Medicaid reimbursement limitations, controls within the Federal Employees Health Benefit programs, HMO and PSRO legislation, and the hospital cost containment bills now pending before Congress are but several examples of congressional and federal policy on health care cost containment. Public policy, as enunciated through various federal insurance programs, calls for involvement of private insurance companies administering federal programs to affect the method and manner of reimbursement to providers of health care for the purpose of containing costs.

The intent of Congress to bring about cost efficiency in virtually all areas of the health care market is essentially manifest in the 1974 National Health Planning and Resource Development Act.[25] Congressional findings conclude that "[i]ncreases in the cost of health care . . . have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care."[26] Among the national health priorities identified by Congress in this Act is the development of simplified reimbursement methods for

[25] *Id.* § 300k (Supp. 1977).

[26] *Id.* § 300k(a)(4) (Supp. 1977).

health service institutions. To this end, grants for optional state rate regulatory programs were authorized. To qualify for grants, the state programs should "create incentives at each point in the delivery of health services for utilization of the most economical modes of service feasible" and employ methods "for determining the reimbursement rates . . . and . . . rates of change in the reimbursement rates. . . ."[27]

Bringing effective reimbursement controls to the health care market is a central objective of federal health planning policy. State authorized and supervised rate control mechanisms constitute one major approach. Alternative delivery modes, peer review and use of insurance company reimbursement leverage are also employed in the public and private sectors to influence the method and manner of reimbursement. Although various methods are employed, the federal government's policy to contain health care costs through the exercise of some control over provider reimbursement is clear.

b. Enunciated State Policy. Public policy as developed at the state level parallels federal objectives for cost containment initiatives. Pressures for cost controls come principally from those parties who bear the burden of paying for health care: government, third party payers, labor unions, corporations and private citizens. State governments have become financially involved in this cost spiral as their share of Medicaid program costs has pressured state budgets.[28] As a result, state efforts are now growing to bring about more effective cost controls on the health care market.

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[27] *Id.* § 300m-5(b)(2) (Supp. 1977).

[28] Data from 1974 reveals that state contributions to their Medicaid plans ranged from 17% to 50%, with state costs varying from $2 million in Wyoming to over $1 billion in New York. DATA ON THE MEDICAID PROGRAM, *supra*, note 18, at 27-28.

Governor Hugh Carey of New York, for example, is submitting legislation to secure a data base to monitor levels of payments to health care facilities. According to Governor Carey, "[e]ffective planning and control of health resources depends on controlling reimbursement rates paid to . . . hospitals and other health care facilities."[29] While the initial response of federal and state governments has been to control Medicare and Medicaid reimbursement levels, attention is being shifted towards all payer classes. Governor Carey's intent to monitor levels of payments evinces the broad reach of state interest.

Several states have enacted legislation creating cost containment agencies. For example, Maryland's Health Service Cost Review Commission was created

> to assure to all purchasers of health care institutional services that the cost of said institutions are reasonably related to the total services offered . . . and to provide that the rates set . . . are in reasonable relation to their aggregate cost. . . .[30]

Agencies similar to the Maryland Commission have been created in a number of other states and proposed in several more states.[31] The purpose of these enactments is to provide regulatory means to assure that health care facilities control capital expenditures, introduce incentives to operate efficiently and offer the lowest cost service possible while maintaining high quality care.

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[29] GOVERNOR HUGH L. CAREY, STATE OF THE HEALTH MESSAGE: SPECIAL MESSAGE TO THE NEW YORK LEGISLATURE 7 (Feb. 15, 1978).

[30] Synopsis to S.B. 359, ch. 627 [1971] Laws of Maryland 1129.

[31] *E.g.*, CONN. GEN. STAT. § 19-73i (1977); MASS. GEN. LAWS. ANN. ch. 6A, §§ 31-46 (Supp. 1977); WASH. REV. CODE ANN. § 70.39.160 (West 1975). *See also* Lemer & Willman, *Rate Setting*, in TOPICS IN HEALTH CARE FINANCING at 141-43 (Vol. 1, No. 2 1974).

State insurance regulatory interest in cost containment is longstanding. In the 1914 landmark decision, *German Alliance Insurance Co. v. Lewis,* 233 U.S. 389 (1914), this Court held that a commissioner of insurance could regulate insurance rates on the basis that insurance is affected with a public interest. In the health insurance area, the direct rate regulation of Blue Cross and Blue Shield in most states provides the insurance commissioner with leverage to encourage these insurers to undertake cost containment efforts. For example, in denying a recent Blue Cross rate increase request in Illinois, the Illinois Director of Insurance emphasized that "we should recognize the importance of vigorous and affirmative efforts by the state's largest health insurer to pressure cost containment."[32] In addition to directly regulating premium rates to subscribers, several states also regulate the rate of reimbursement to hospitals.[33] Because of the significance of the health care provider agreements with Blue Cross and Blue Shield, insurance regulatory interest in these contracts is hardly surprising:

> Hospital reimbursement schedules and doctors' fee schedules are at the core of the relationship between [Blue Cross and Blue Shield] associations and those who render services for subscribers. . . .[34]

Policy benefits, claims settlement procedures and premium rates are directly affected by reimbursement schedules. Statutory authority for insurance commissioner review of reimbursement agreements underscores both the

[32] National Underwriter, April 1, 1978, at 23, col. 1.

[33] *E.g.,* MICH. COMP. LAWS ANN. § 550.503 (Supp. 1978); OHIO REV. CODE ANN. § 1739.051 (Page Supp. 1976); PA. STAT. ANN. tit. 40, § 1558 (Purdon 1971).

[34] R. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 178 (1963).

relationship of such agreements to the business of insurance and state policy to contain costs.

The states have also focused upon the development of health maintenance organizations (HMO's) as an alternative health care delivery system to, among other things, contain health care and health insurance costs. Although the federal government is engaged in providing start-up capital to HMO's under the Health Maintenance Organization Act of 1973,[35] HMO's are creatures of state law. Thirty states have moved since 1972 to provide special enabling legislation for HMO's.[36] Many of the state HMO laws are patterned after the Model HMO Act adopted by the NAIC in 1972.[37] The drafting comments to the NAIC Model Act explain that:

> An HMO, by its very nature, may provide incentive toward lessening costs in delivering health care. It

[35] *See* 42 U.S.C.A. § 300e-3 (1974).

[36] ARIZ. REV. STAT. ANN. § 20-1051 (Supp. 1977); ARK. STAT. ANN. § 66-5201 (Supp. 1975); CAL. HEALTH & SAFETY CODE § 1304 (West Supp. 1976); COL. REV. STAT. ANN. § 10-17-101 (Supp. 1976); FLA. STAT. ANN. § 641.17 (Supp. 1977); IDAHO CODE § 41-3901 (1977); ILL. ANN. STAT. ch. 111.5, § 1401 (Supp. 1977); IOWA CODE § 514B.1 (1977); KAN. STAT. ANN. § 40-3201 (Supp. 1976); KY. REV. STAT. ANN. § 304.38-010 (Baldwin Supp. 1978); ME. REV. STAT. ANN. tit. 24-A, § 4201 (West Supp. 1977); MD. ANN. CODE art. 43, § 840 (Supp. 1977); MASS. GEN. LAWS ANN. ch. 176G, § 1 (West Supp. 1977); MICH. COMP. LAWS ANN. § 325-901 (Supp. 1978); MINN. STAT. ANN. § 62D.01 (Supp. 1978); NEV. REV. STAT. ch. 695C.010 (1975); N.H. REV. STAT. ANN. § 420-B:1 (Supp. 1977); N.J. STAT. ANN. § 26:2I-1 (Supp. 1977); N.Y. PUB. HEALTH LAW § 4400 (McKinney Supp. 1976); N.C. GEN. STAT. § 57A-1 (Supp. 1977); N.D. CENT. CODE § 26-38-01 (1977); OHIO REV. CODE ANN. § 1742.01 (Page Supp. 1976); PA. STAT. ANN. tit. 40, § 1551 (Purdon Supp. 1975); S.C. CODE ANN. § 37-1131 (Supp. 1975); S.D. COMP. LAWS ANN. § 58-41-1 (Supp. 1976); TENN. CODE ANN. § 56-4101 (Supp. 1976); TEX. INS. CODE art. 20A.01 (Vernon Supp. 1975); UTAH CODE ANN. § 31-42-1 (1974); WASH. REV. CODE ANN. § 48.46.010 (West Supp. 1976); W. VA. CODE ANN. § 33-25A-1 (1977).

[37] I NAIC PROCEEDINGS 202-22 (1973).

> has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs.[38]

Substantial state interest in HMO's and insurance regulatory encouragement and involvement further evidence the policy of the states to implement effective cost containment.

Some possibilities for the direction of future insurance industry involvement in containing costs may be gleaned from the NAIC's recently adopted Model Comprehensive Health Insurance and Health Care Cost Containment Act.[39] This model calls for the mandatory offering by insurers of a particular form of comprehensive coverage that includes substantial cost sharing features, extensive health care provider cost controls and other innovative measures to accomplish cost efficiency. Health care provider payment provisions of the model bill authorize insurers to: (1) determine the necessity of care and the reasonableness or adherence to customary charges by providers; and (2) enter into negotiations and agreements for the establishment of direct payment plans under which insurance company payments are accepted in full satisfaction of provider charges.[40]

The involvement of the health insurance industry in limiting the tendency of providers of care to charge whatever insurers can pay is essential in the opinion of the NAIC. State policy to effectuate health care cost containment is clearly evidenced by hospital cost control legisla-

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[38] *Id.* at 204.

[39] II NAIC PROCEEDINGS 407-37 (1976).

[40] *Id.* § 14, at 424-25.

tion, HMO legislation and the activities of insurance regulatory authorities.

2. The Root Causes of Escalating Health Care Costs Require Experimentation With a Variety of Cost Containment Measures.

Both federal and state public policies toward health care cost containment are in the formative stages of development. If these policies are to be implemented successfully they must be allowed wide latitude in experimenting with mechanisms which can be employed to ameliorate the root causes of cost escalation.

a. The Root Causes of Cost Escalation. Two basic causes underlie the escalation of health care costs and hence the cost of health insurance. *First, the operation of the medical care system lacks internal incentives for cost constraint and contains internal incentives that result in cost escalation.* These include, for example, (a) fee for service which provides economic reward for utilizing more services and more expensive services, (b) retrospective cost reimbursement for institutional providers, (c) prestige of high cost specialization, (d) concentration of providers in areas with good facilities, and (e) excess hospital bed capacity in many areas causing higher unit costs and incentive to increase utilization beyond needed levels to recover fixed cost of under-utilized services and facilities.

Second, the third party system (whether a government program such as Medicare or Medicaid or private insurance) insulates those who make the decision concerning the nature and quantity of health care services — the patient and the physician — from the direct economic consequences of such decisions. This third party payment system eliminates the major restraint for the demand for

health care services whether or not they are medically necessary.[41] In other words, competition is ineffective in maintaining a proper market for health services:

> The immunity of the hospital industry from the traditional incentives and penalties of the free enterprise system . . . is the critical factor in the uninhibited rise of hospital charges and costs.
>
> . . . .
>
> The user of the service — the patient — rarely pays. Ninety percent of the hospital bills are paid by third party payers. Thus, the patient never has a sense of the exorbitant price of the service he receives.
>
> The user of the service — the patient — does not choose the service. His doctor usually tells the patient what he needs. The current system of third party payers reimbursing hospitals for whatever the cost-plus, sole source price is, has created a "spend-more, get-more" attitude.[42]

Since the physician typically selects the mode and extent of hospital, medical, prescription and other related health care services, both the demand and supply decisions tend to coalesce under the physician's control. Thus, the decisions in the health care field are primarily made by persons with few incentives and several disincentives to deliver health care in a reasonably economic and efficient

[41] The underlying structural characteristics of the health care industry, the prevelance of public private insurance coverage, and the reimbursement practices of these third parties have resulted in chronic inflation in health care costs. . . . The inflationary effects of these reimbursement methods are clearly exaggerated by the virtual guarantee of payment by a public or private insurer and the dependence of the consumer on the medical care provider. *Hearings on S. 3205, supra* note 21, at 29-30. *See also* FORWARD PLAN FOR HEALTH, *supra* note 14, at 32; M. FELDSTEIN, THE RISING COST OF HOSPITAL CARE 76 (1976).

[42] *Joint Hearings on H.R. 6575, supra* note 13, at 14.

manner.[43] Cost escalation for all insured health services is an unfortunate byproduct of the third party payment system and the lack of effective competition in health care delivery.

b. The Need for Experimentation With Methods to Contain Health Care Costs. Increasing coverage under third party insurance payment systems (whether government or private) emphasizes the necessity for an improved cost containment system. Various approaches and techniques have been suggested and/or experimented with to contain the escalation of health care costs.

(1) Rate Controls. One approach which has been developed to reduce costs is the direct imposition of rate controls on hospitals and physicians by government. For example, the imposition of a rate review system over hospital costs and charges offers a means to interject cost constraint incentives into the administration of health care delivery systems leading towards improved budgeting, justification of capital expenditures and development of internal systems to monitor costs. Cost restraint incentives can likewise be created for physician fees through such actual and suggested techniques as professionally-established rate schedules, peer review of the reasonableness of fees, negotiated fee schedules and government-mandated charges. On the other hand, there are indications that governmental control of hospital and physician charges lacks effectiveness, poses administrative difficulties, and may adversely affect the quality of health care.

[43] To the extent that potential medical malpractice liability induces the practice of "defensive medicine" by physicians, overutilization of health care resources is further aggravated. *See* U.S. DEP'T OF HEALTH EDUC. & WELFARE, REPORT OF THE SECRETARY'S COMM. ON MEDICAL MALPRACTICE 14 (1973).

The extent to which a government should become involved in the delivery of health care raises a fundamental public policy question. It should be noted that direct regulation functions most efficiently when only a few large organizations are involved. In contrast, comprehensive regulation of the health care delivery system with its large number of small units (e.g., hospitals, physicians) is likely to be very complex, thus generating pressure over a period of time to consolidate into a relatively few delivery units. A potential result of direct government regulation of rates, then, is a more centralized health care delivery system which is less attuned to local circumstances and individual needs than the present system. This additional consideration also suggests that there may be limits to the feasibility of government rate controls as a cost control mechanism.

(2) Cost Sharing. A second general approach to containing the cost escalation inherent in the third party payment mechanism is to require cost sharing by the consumer. If the consumer significantly bears a direct and visible portion of the cost of using health care at the point of service, he may be induced to economize in the selection and use of services. Various cost sharing devices include insurance policy deductibles, coinsurance, exclusions and/or maximum coverage limits. Although these techniques may be effective in inducing persons to refrain from seeking health care services, they may also raise inappropriate barriers to needed care. Thus, the design of the deductibles must be carefully considered. There is no assurance that this approach will encourage sufficient cost containment and simultaneously avoid deterrence to needed care.

(3) Insurer Cost Containment Efforts. A variant on both the direct government control and consumer cost sharing approaches to cost containment is to vest authority and responsibility in insurers, subject to state regulatory oversight. A variety of techniques and approaches are available to insurers, with a most promising one being to allow or encourage insurers to negotiate prices of health care purchased by insurance benefits. Negotiated reimbursement contracts of Blue Cross and Blue Shield are current examples of this approach. Although not endorsing this approach as necessarily the only or best method, several reasons commend it as an appropriate and worthwhile approach.

First, as evidenced by statutory language, regulations and policy statements, there is widespread feeling that, since the private insurance system (as well as the government insurance program) is a prime cause in the escalation of health care costs, it should also bear major responsibility in containing costs. Second, a health insurer is in effect a substitute purchaser of consumer services. As such it may have market power to bring pressure on health care providers' prices, quality and patients' utilization of services while acting in the best interests of its insured-health care consumers. Third, the private insurance system has undertaken a wide variety of programs to contain costs. As a general proposition, it is usually better to build upon and improve an existing system than to start from scratch. This is particularly true in the absence of convincing evidence of the superiority of alternative approaches. Fourth, the delivery of health care is a very multi-faceted industry requiring a variety of cost measures. Utilization of the private insurance industry makes available an existing vast resource of people and funds to tackle the cost containment problems on a flexible and local basis.

It is not the purpose of this *amicus curiae* brief to resolve the multitude of public policy questions pertaining to the containment of health care costs and, thereby, the containment of the costs of health insurance and other types of insurance coverages which provide health benefits. By virtue of this brief, however, the NAIC hopes to provide some indication of the breadth of the problem and the urgent need to experiment with a variety of approaches in order to find acceptable and effective solutions. One of the most promising approaches is vesting authority and responsibility in insurers, subject to appropriate state regulation, to develop and implement cost containment measures. But certitude concerning the merits of various programs and the best balance in combining various programs is still on the distant horizon. Thus, continued effort and experimentation with promising approaches is essential if the public policy of health care and health insurance cost containment is to be achieved.

3. Implications of the Lower Court's Decision for the Public Policy of Health Care Cost Containment.

By finding that the Blue Shield program does not constitute the "business of insurance," the lower court in the instant case exhibited little reluctance to deny an insurer a role in the containment of health care costs. The court explicitly stated that

> Blue Shield is not required to guarantee the provision of services on a "cost plus" basis *or any* other *basis which might be more economical* than the retail purchase of such products. That Blue Shield may wish to protect itself and its consumers from rising costs in the pharmaceutical industry does not transform the Pharmacy Agreement into the business of insurance. In fact, *the best way for the firm to protect itself from rising costs is to establish and periodically adjust its rate structure to reflect the impact of inflation.* 556 F.2d at 1382 (emphasis added).

The court sees the insurer's role as nothing more than a bill payer with no responsibility to contain the underlying costs and no proper interest in making health insurance available to the consumer at a lower price. There are serious public policy ramifications of such a narrow perspective of an insurer's role in cost containment.

The lower court's perception of the insurer's role ignores economic reality. Because of the volume of reimbursement payments it is obligated to make, an insurer's activities inevitably impact upon the market for services of health care providers. An insurer cannot escape responsibility for contributing to the escalation of health care costs due to the inherent nature of the third party payment system. By denying insurers an opportunity to assume this responsibility and respond to public pressures, the lower court runs roughshod over the public's need for limits on health care expenditures. Such result directly conflicts with the public policy of health care cost containment enunciated at both federal and state levels of government.[44]

B. The Public Policy of Cost Containment in Other Lines of Insurance.

The public policy supporting cost containment initiatives by health insurers is parallelled by expressions of public policy applicable to other lines of insurance. An example of insurance cost problems outside the health care context is the testimony of the National Traffic Safety Administrator before the Senate Commerce Committee that consumers "spend about $13-17 billion in the

[44] *See* notes 14-40 *supra* and accompanying text.

United States on unnecessary automotive repairs."[45] One study demonstrates that replacement of all parts on a totally wrecked 1977 standard automobile with a list price of $4,631 would produce an aggregate repair bill of $21,471.[46] Escalation in prices of automobile repair parts has, similar to medical care, outpaced the inflation rate for other goods and services.[47] Under automobile liability coverages, an insurer in effect is a mass purchaser of medical services, legal services and car repairs. The inflationary pressures in these areas, in turn, impact upon the cost of insurance. Without review of the reasonableness of charges, automobile insurers and their policyholders would be subject to uncontrolled inflation in the repair market.

If the fifth circuit's decision is affirmed by this Court, the precedent thus set is likely to cause insurers to avoid practices that may be construed as efforts to affect the method of reimbursement to those providing services to insureds. If insurance company efforts to control reimbursement rates to health care providers give rise to antitrust violations, reimbursement controls in other lines of insurance will be similarly subject to challenge. The sanction of cost containment efforts offered by *Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977) would be undermined. Compelling the insurance mechanism merely to indemnify insureds for their purchase of lost or damaged goods or services will

[45] *Hearings on S. 2604 Before the Subcomm. on the Consumer of the Senate Comm. on Commerce, Science and Transportation,* 95th Cong., 2d Sess. — (Mar. 21, 1978) (testimony of Joan Claybrook, Administrator, National Highway Traffic Safety Administration).

[46] *What's Driving Up Auto Insurance Costs?* 53 J. OF AMERICAN INSURANCE 9 (Spring 1977).

[47] Between 1972 and 1977, the average insurance loss payment per collision claim increased more than 54%. *Id.*

exacerbate the pattern of increased loss payments which are passed directly and immediately to policyholders in the form of higher prices. We perceive no public benefit or offset to the added cost burden that would result from providers of insured goods and services being free to exploit the third party insurance payment mechanism. Public policy could not be more obviously violated.

C. The Public Policy of State Insurance Regulation.

1. Continuing State Regulation.

The basic purpose of the McCarran Act is quite clear. Congress has declared that "the continued regulation . . . by the several states of the business of insurance is in the public interest . . ." 15 U.S.C. § 1011 (1970). Shortly after its enactment, this Court said "[o]bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Insurance Co. v. Benjamin,* 328 U.S. 408, 429 (1946). This Court more recently affirmed this conclusion in *SEC v. National Securities, Inc.,* 393 U.S. 453, 459 (1969) when it said that the McCarran Act was an attempt "to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." There are strong public policy considerations supporting this congressional mandate.[48]

[48] These public policy considerations are, first, that state regulation of insurance is closer to the people. Because major problems in insurance regulation involve local market conditions — availability of coverage, the price of coverage and the handling of claims — both the means and the incentives to regulate the market conduct of insurers are better handled at the state level. *See* Stewart, *Pressure and Results in Insurance Regulation,* in REASON & REGULATION, SELECTED SPEECHES OF RICHARD E. STEWART 49 (1971). An insurance commissioner and top members of his staff, for example, are more accessible

The lower court's decision works contrary to the congressional intent under the McCarran Act as interpreted

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to personally respond to public needs than their counterparts in the federal bureaucracy.

Second, state regulation offers many advantages of pluralism, experimentation and diversity of regulatory philosophy. *See id.* at 49-50; S. KIMBALL & H. DENENBERG, INSURANCE, GOVERNMENT, & SOCIAL POLICY 415 (1969). A decentralized system of insurance regulation provides maximum flexibility while tailoring regulatory efforts to individual needs. The dispersion of decisional responsibility and power tends to restrict gravity of mistakes and miscalculations while simultaneously encouraging adoption of innovative techniques which have been tested and proven workable elsewhere.

Third, it is significant that there already exists an ongoing and time-tested system for regulating insurance at the state level. Stewart, *supra,* at 47-48. No industry could have thrived for the past one hundred years to the extent of the insurance industry if either the philosophy or administration of state regulation had been unsound. If regulatory jurisdiction over the insurance industry is transferred from state government to the federal government — either gradually or in one step — much of the experience and expertise now residing in state insurance departments would be lost.

Fourth, an extremely important and unique advantage of state insurance regulation is the system of governmental accountability due to the threat of a federal alternative. Because state insurance regulation is subject to extinction by Congress, state regulators are particularly sensitive to congressional oversight — more so than federal agencies to which there is no credible alternative. *Id.* at 50.

Finally, there is much to be said for preserving the concept of federalism by delegating to the states the authority to regulate the business of insurance. As our recent national experience with abuses of presidential power suggest,

> Decentralization and dispersion of political power is in itself an important value in a democratic society. Concentrations of power are bad, per se, and it is irrelevant whether the concentrations are in government, in labor, or in business. . . . Any problems that can be dealt with adequately at the state level *should* be handled there in preference to Washington. S. KIMBALL & H. DENENBERG, *supra,* at 416.

Senator Ferguson voiced identical concerns when he noted in the debates surrounding the McCarran-Ferguson Act: "[W]e believe that all the wisdom is not here in Congress." 91 CONG. REC. 1481 (1945).

by this Court. By unduly narrowing the definition of what constitutes a part of the "business of insurance" the lower court would subject certain insurance activtities to antitrust sanctions; this result would impede the ability of the states to regulate insurance by injecting tremendous uncertainty into the scope of insurance regulation. This is particularly evident where state insurance commissioners review efforts by insurers to foster and sanction lower insurance costs.

2. Allocation of Regulatory Responsibility Over Insurance Cost Containment.

The lower court's decision poses ramifications extending far beyond the facts in the instant case and the interests of the immediate parties involved. The determination whether an insurer's efforts to reduce or contain the cost of insurance constitutes a part of the "business of insurance" also determines the allocation of regulatory responsibility for containing such costs. Reaffirmation of the decisions in numerous district and circuit courts, with the corresponding reversal or modification of the Fifth Circuit Court of Appeals' decision in the instant case, would leave primary responsibility with the states vis-a-vis the federal antitrust laws. Affirmation of the firth circuit decision would either deter or foreclose a variety of state mandated or sanctioned efforts to resolve the cost containment problems.

A fundamental public policy issue before this Court, therefore, is who should determine the metes and bounds of appropriate activity designed to contain insurance costs? Should the responsibility be vested in the federal courts under the antitrust laws in the context of *ad hoc* litigation or in the state insurance commissioner in the context of continuous administrative supervision?

[T]he more knowledgeable consumer sees insurance regulation as serving three goals. (1) He wants to be able to buy insurance — conveniently — to get what he needs. (2) The insurance must be reasonably priced. (3) The insurance must be good — that is, the company should be able, at all times, to discharge the financial obligations it has assumed in its contract. These three objectives are sometimes wrapped up in three words: (1) availability, (2) price, and (3) solidity.

If the prospective insured cannot obtain insurance at all, price and solvency become immaterial. Or, if the insurance is available but the price is so high as to put the coverage out of reach for all pracical purposes, solvency is again immaterial. When a company fails, the availability of coverage in the first instance or the price charged for it becomes immaterial. Lack of solidity then becomes an important consideration. There is increasing recognition that all three goals are tied together.[49]

Each insurance commissioner is on the public "firing line" to achieve publicly perceived objectives of insurance regulation — availability of insurance, reasonable price, fair treatment of claims and insurer reliability. To achieve these insurance regulatory goals, extensive insurance regulation has evolved in the various states in such areas as rating laws, policy form controls, solvency standards, approval mechanisms as to reimbursement contracts with health care providers, unfair trade practices acts, etc. The manner in which insurers are to provide insurance benefits to insureds at reasonable rates is the very type of regulatory problem which state insurance commissioners are the most competent to examine. The

[49] J. Hanson, R. Dineen & M. Johnson, Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business 98 (1974).

insurance commissioner deals directly with the *substance* and *fairness* of the interrelated insurance regulatory problems of which cost containment is one. In contrast, application of the federal antitrust laws deals more with the *form* rather than *substance* of market activity in its pursuit of the question whether or not there is a conspiracy in restraint of trade.[50] In short, the state insurance commissioner is better positioned to come to grips with the problems relating to containing underlying cost of insurance and balancing the interests of individual claimants and those policyholders who fund the insurance benefit mechanism through premium payments.

D. The Public Policy of Antitrust and Its Relation to Health Care Costs.

The fifth circuit would subject Petitioners' cost containment activities to antitrust scrutiny and possible sanctions. A fundamental objective of the antitrust laws is to encourage the "lowest prices" for goods and services in the marketplace. *See Northern Pacific Railway Co. v. United States,* 356 U.S. 1, 4 (1958). *See also United States v. International Harvester Co.,* 274 U.S. 693, 701 (1927). Antitrust attempts to achieve its goals through the maintenance of competitive markets. Report of the Attorney General's National Committee to Study Antitrust Laws 1 (1955).

In the fact situation of the instant case, Blue Shield extended an offer through the mail to each individual pharmacy owner to participate under an agreement for providing drugs to Blue Shield policyholders at a price contractually agreed to be the pharmacist's acquisition

[50] *See* P. Asch, Economic Theory and the Antitrust Dilemma 281-84 (1970).

cost plus a $2.00 dispensing fee. Each pharmacy was free to accept or reject the offer. The individual offers made to pharmacies in and of themselves posed a reasonable means to determine an adequate and reasonable reimbursement rate. The acceptance of the offer individually by several pharmacies, including certain individual Respondents,[51] suggests an adequate level of reimbursement. The fact that Blue Shield's reimbursement plan was effective in putting downward pressure on retail drug prices suggests that competition had not previously fully encouraged the lowest possible prices.[52] Thus, in effect, we have the spectacle of the Respondents urging that the antitrust laws be used to avoid the "lowest prices" contrary to the basic purpose of antitrust laws.[53] To construe the term "business of insurance" not to include an insurer program aimed at the reduction or containment of the cost of insurance would uphold a perverse application of the antitrust laws and ignore economic reality.

Moreover, the structure of the health care delivery system does not fit within the parameters of what is needed for an effective competitive market. Reliance on the application of the antitrust laws as the primary mechanism to contain costs would not only be an illusion, it could also deter or prohibit other promising approaches. For

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[51] Nine Respondents accepted the Pharmacy Agreement offered by Petitioners. 556 F.2d at 1378.

[52] While price escalation for drugs in recent years has been below that for other medical costs, third party prescription drug coverage has only recently become widespread. *See* 1977 STATISTICAL ABSTRACT, *supra* note 12, at 97. To the extent that third party reimbursement is responsible for general health care cost escalation, the recent trend towards prepaid drug coverage can be expected to generate price escalation paralleling that for other health services.

[53] Respondents alleged that the Pharmacy Agreement set prices at a level below that at which some of the small independent pharmacies could profitably operate. 556 F.2d at 1375, 1378.

this reason, the public policy of antitrust does not support the lower court's decision in the instant case whereas the other public policies demand that the decision be reversed.[54]

The Respondents also suggest that, if the challenged activities of Blue Shield are claimed to be the business of insurance, private insurers would enjoy untrammelled freedom to enter into contracts with suppliers of goods and services thereby setting prices in various segments of the economy. This contention lacks merit for at least two reasons, First, even if a challenged activity constitutes the "business of insurance" the McCarran Act still does not bar the application of the antitrust laws if the state has not regulated or if the activity constitutes a boycott, coercion or intimidation. Thus, in the type of situation presented by the instant case, if the state does not afford protection by regulating an insurer's activity to reduce or contain costs, the antitrust laws would still apply. Second, as noted earlier, the NAIC does not maintain that there are no outer limits to what constitutes the "business of insurance." But, from both legal and public policy viewpoints, insurer efforts to reduce or contain the cost of insurance through claims settlement procedures clearly and comfortably fits within these limits. The state regulation and boycott provisions of the McCarran Act and the limited standard submitted by the NAIC in this instant case

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[54] In this connection, it is interesting to note that the current chairman of the FTC, one of the two federal antitrust enforcement agencies, has suggested that "Blue Shield plans could take steps to reduce these inflationary aspects of their payment mechanisms." *Hearings Before the Subcomm. on Oversight and Investigations, supra* note 15, at ——.

militate against the Respondents' alleged fears of unrestrained private activity.[55]

The foregoing discussion confirms the general awareness and recognition that there exists a strong public policy to reduce or contain those costs which underlay the cost of insurance with particular reference to such areas as health care. In addition the McCarran Act has long established the sound public policy of vesting primary responsibility in the states for regulating the business of insurance. As a result, as between the states and federal antitrust, there is further public policy of allocating to the state insurance regulators the primary responsibility to reduce or contain costs of insurance. Each of these public policies urge reversal of the lower court's decision in the instant case.

The Respondents, however, are asserting that the public policy of the antitrust laws lead to the contrary conclusion. In construing the scope of the "business of insurance" in the existing case, this Court is inescapably confronted with the problem of balancing these sometimes competing public policies. However, the affirmance of the lower court's decision in this case would not only ignore the major public policies of (1) health care and insurance cost containment, (2) continued state insurance regulation, and (3) allocation of regulatory responsibility for cost containment to the states, such affirmation would also uphold a perverse application of the antitrust laws and defeat the antitrust public policy of lower costs.

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[55] In evaluating the Respondents' argument, it is worth noting that it is premised on economic *un*reality. The Repondents would have the courts believe that the various segments of the economy can be compartmentalized and not impact upon each other. This is obviously in error. An insurer is, in effect, a substitute consumer of large quantities of products and services. As such, the insurer will impact on the price structure in those markets regardless of the existence of a written contract.

SUMMARY OF ARGUMENT

The price which an insured pays for insurance is a fundamental element of the "business of insurance" under the McCarran Act. It follows that efforts to contain escalating prices must likewise be considered a part of the "business of insurance"; they significantly affect the insurer-insured relationship through their impact on the rate paid to insurers by insureds. In applying the standards of the *National Securities* case several circuit and district courts have reached this very conclusion. The lower court's various rationales in the instant case, upon which the opposite result is based, defy reason and lack legal relevance.

But more importantly, the public policy of health care cost containment dictates that insurer cost control efforts be considered a part of the "business of insurance." Although there are several approaches available for halting the escalating spiral of modern health care costs, one extremely attractive approach is the claims settlement procedures of insurers which focus on cost containment. The lower court's decision would nullify these procedures by allowing providers of goods and services to avoid their cost-limiting impact. Given proper regulatory supervision under state insurance laws, the NAIC believes that cost containment efforts of insurers which focus on claims settlement procedures will not overstep the bounds of acceptable economic conduct. The public policy of health care cost containment requires that such efforts at least be given an opportunity to counteract the forces which generate spiraling insurance costs.

The public policy of health care cost containment is not the only public policy which necessitates a finding

that insurer cost control efforts be considered a part of the "business of insurance." Because the Court's decision in this case will affect cost control efforts of insurers in other lines of insurance, the broader public policy of minimizing all types of insurance costs supports the position that cost containment efforts be included within the phrase "business of insurance." Similarly, the public policy of continued state insurance regulation, as embodied in the McCarran Act, leads to the conclusion that cost containment efforts of insurers be considered the "business of insurance." Even the public policy of "lowest prices" under the antitrust laws offers more support to the Petitioners' view of the "business of insurance" than to the lower court's narrow perspective. If that court's decision is upheld by this Court there is little doubt that various public policies will be seriously compromised at the expense of illusory antitrust objectives.

CONCLUSION

The NAIC believes that the lower court's decision in this case precludes an essential alternative for curbing the spiraling costs of health care services today — insurer cost containment efforts — by making such efforts vulnerable to antitrust litigation. Sound logic, legal precedent and public policy dictates that an insurer's activities designed to reduce or contain the cost of health care be considered a part of the "business of insurance under the McCarran Act and exempted from antitrust sanctions. Any other result would do a great disservice to the insurance-consuming public.

Respectfully submitted,

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